INQUIRY COMMITTEE
RECORD OF DECISION

FILE NAME: DH1293

FACTS

On February 3, 2012, the Complainant filed a complaint with the College alleging that the Registrant had engaged in unauthorized practice by extracting a tooth from a client who was a resident at a Care Facility. By letter dated February 14, 2012, the Registrar of the College notified the Registrant of the complaint and invited a response in accordance with section 33(5) of the *Health Professions Act,* R.S.B.C. 1996, c. 183 (the "*Act*"). The Registrant provided a response in which (s)he described the events which lead to the complaint being made and acknowledged performing a tooth extraction. The Inquiry Committee appointed an inspector under s. 27 of the *Act* on March 5, 2012.

The Complainant advised the inspector that she was informed by an employee and nurse at the Care Facility that the Registrant had extracted a tooth for a resident who suffers from dementia and is unable to consent to care. She advised that: (a) the nurse was unaware that the resident required an extraction; (b) the nurse was not consulted regarding the proposed treatment; and (c) the nurse did not consent to the proposed treatment. The Complainant indicated that standard procedure would be to notify and consult with the nurse on duty and coordinate consent from a family member (s) who has authority to consent for the resident's treatment. The Registrant advised the inspector that (s)he was concerned for the client's level of distress caused by the loose tooth and that (s)he had used Oraqix to anesthetize the gingival tissues/area or tooth and manually removed the loose tooth. The Registrant acknowledged that extractions were not a part of the curriculum in the dental hygiene program (s)he studied.

COMMITTEE DECISION

The Inquiry Committee was concerned that the Registrant provided services without obtaining prior informed consent, failed to adequately document details of treatment in the clinical record, performed treatment outside the scope of practice of a dental hygienist by extracting a tooth, failed to consult with the resident's family representative and dentist or other applicable health care providers prior to extracting the tooth, and failed to recommend referral to a dentist for dental treatment which was outside the scope of practice for a dental hygienist. At the conclusion of the investigation the Inquiry Committee determined, under s. 33(6)(c) of the *Act*, that this would be an appropriate case to seek a consent order under s. 36 of the *Act*.

The Registrant agreed to provide a consent order pursuant to ss. 36(1)(a) and (d) of the *Act* on terms requiring her/him to undertake not to repeat the conduct of providing treatment without obtaining prior informed consent, undertaking not to repeat the conduct of failing to consult with the client or client's representative, undertaking not to repeat the conduct of failing to consult with the client's dentist or other applicable health care provider where a client requires services outside scope of practice, undertaking to notify the College of Dental Surgeons of British Columbia as soon as it is apparent that dental services cannot be arranged for a client in a facility and undertaking not to repeat the conduct of failing to complete proper charting.. The Inquiry Committee was satisfied that these terms would enable the College to monitor the Registrant's practice skills and ensure that there is no risk to public safety.

RELEVANT PROVISION OF ACT, REGULATION, OR BYLAWS: *Act, section 27; 32(1) and (2); 33(5); 33(6)(c); 36(1)(a) and (d) and Bylaws, section 70*

***STATUS*: Closed**

LEGISLATIVE AUTHORITY: *Health Professions Act s 33, 36*